~~under the supervision of a physician who also qualifies as a PCP under this contract and specialize in family practice, internal medicine, pediatrics or obstetrics/gynecology.~~ Provider types practicing within the scope of their respective Practice Acts may be doctors of medicine (MDs), doctors of osteopathic medicine (DOs), nurse practitioners, and physician assistants.

Primary care services: All health care services and laboratory services customarily furnished by or through primary care provider ~~a general practitioner, family physician, internal medicine physician, obstetrician/gynecologist, or pediatrician~~, to the extent the furnishing of those services is legally authorized in the State in which the practitioner furnishes them.

Product: Something that is distributed commercially for use or consumption and that is usually (1) tangible personal property, (2) the result of fabrication or processing, and (3) an item that has passed through a chain of commercial distribution before ultimate use or consumption.

Project: The total scheme, program, or method worked out for the accomplishment of an objective, including all documentation, commodities, and services to be provided under a contract.

Proposal: See Bid/Proposal.

Proprietary Information: Proprietary information is defined as trade secrets, academic and scientific research work which is in progress and unpublished, and other information that if released would give advantage to business competitors and serve no public purpose (see Neb. Rev. Stat. §84-712.05(3)). In accordance with Attorney General Opinions 92068 and 97033, proof that information is proprietary requires identification of specific, named competitor(s) who would be advantaged by release of the information and the specific advantage the competitor(s) would receive.

Protest: A complaint about a governmental action or decision related to an Invitation to Bid or resultant contract, brought by a vendor who has timely submitted a bid response in connection with the award in question, to AS Materiel Division or another designated agency with the intention of achieving a remedial result.

Provider: Any individual or entity furnishing Medicaid services under an agreement with the Medicaid agency under the FFS model, or for the managed care program, any individual or entity who/that is engaged in the delivery of health care services and is legally authorized to do so by the State in which it delivers the services.

Public Proposal Opening: The process of opening correctly submitted offers at the time and place specified in the written solicitation and in the presence of anyone who wished to attend.

Qualifying revenue (for the risk corridor calculation): The aggregate of revenue earned by a MCO and related parties, including parent and subsidy companies and risk bearing partners under this contract, including capitation payments and ignoring federal and state premium taxes and non-operating income. Any earned hold-back is not factored into the calculation.

Qualifying revenue (for the administrative cap calculation): The aggregate of revenue earned by the MCO and related parties, including parent and subsidy companies and risk bearing partners under this contract, including capitation payments and ignoring federal and state premium taxes and non-operating income. The hold-back (earned and forfeited) is factored into the calculation.

Quality improvement (QI) administrative rate: Equals the QI Expenses divided by Qualifying Revenue.

Quality improvement (QI) expenses: These are expenses for the direct interaction of the insurer, providers and the enrollee or the enrollee's representatives (e.g., face-to-face, telephonic, web-based interactions or other means of communication) to improve health outcomes as defined below. This category can include costs for associated activities such as:

1. Effective case management, Care coordination, and Chronic Disease Management, including:
    - **a.** Patient centered intervention such as:
        - i. Making/verifying appointments;
        - ii. Medication and care compliance initiatives;
        - iii. Arranging and managing transitions from one setting to another (such as hospital discharge to home or to a rehabilitation center);
        - iv. Programs to support shared decision making with patients, their families and the patient's representatives;
        - v. Reminding insured of provider appointment, lab tests or other appropriate contact with specific providers;
        - vi. Incorporating feedback from the insured to effectively monitor compliance;

vii. Providing coaching or other support to encourage compliance with evidence based medicine;
viii. Activities to identify and encourage evidence based medicine;
ix. Activities to prevent avoidable hospital admissions;
x. Education and participation in self-management programs; and
xi. Medication and care compliance initiatives, such as checking that the insured is following a medically effective prescribed regimen for dealing with the specific disease/condition and incorporating feedback from the insured in the management program to effectively monitor compliance.

b. Improve patient safety;
c. Wellness and health promotion activities;
d. Health Information Technology (HIT) expenses related to Quality Improvement Activities:
i. Data extraction, analysis and transmission in support of the activities described above; and
ii. Activities designed to promote sharing of medical records to ensure that all clinical providers and accurate records from all participants in a patient's care.

2. The following items are broadly excluded as not meeting the definitions above:
a. All retrospective and concurrent Utilization Review;
b. Fraud Prevention activities;
c. The cost of developing and executing provider contracts and fees associated with establishing or managing a provider network;
d. Provider Credentialing;
e. Marketing expenses;
f. All Accreditation Fees;
g. Costs associated with establishing or maintaining a claims adjudication system;
h. Costs associated with calculating and administering individual enrollee or employee incentives; and
i. Any function or activity not expressly listed as approved.

Quality management: The continuous process of assuring appropriate, timely, accessible, available, and medically necessary delivery of services. Maintaining established guidelines and standards reflective of the current state of physical and behavioral health knowledge.

Readiness review: MLTC's assessment of the MCO's ability to fulfill the RFP requirements. Such review may include but not be limited to review of proper licensure, operational protocols, MCO standards, and MCO systems. This review may be done as a desk review, on-site review, or combination and may include interviews with pertinent MCO personnel.

Re-enrollment: The process by which the State automatically re-assigns a member who is disenrolled solely because he or she loses Medicaid eligibility, when a loss of eligibility does not exceed two months, into the same MCO.

Reinsurance: An insurance product, also known as stop-loss insurance, risk control, or excess insurance, which provides protection against catastrophic or unpredictable losses. An MCO may purchase reinsurance to protect itself against part or all of the losses incurred in the process of honoring the claims of members.

Reinvestment account: The account a MCO must establish for any profits in excess of the contracted amount, performance contingencies imposed by MLTC, and any unearned hold-back funds, pursuant to Neb. Rev. Stat. §71-831-.

Related-party: The parent company of a MCO or an entity partially or wholly owned by the MCO or the MCO's parent company that receives any revenue from the MCO for Medicaid contracted services. Examples of related parties include a clinic wholly or partly owned by a MCO or its parent company that provides services covered by Nebraska Medicaid and subcontractors to the MCO performing services under this contract.

Related-party administrative expense: ~~Fees paid by a MCO, or any of its subsidiaries, to a related party such as a parent organization. Such fees are not considered in the calculation of administrative expense under this contract.~~ Fees paid by a MCO, or any of its subsidiaries, to a related party such as a parent organization such as flat monthly administration fees. Such fees are not considered in the calculation of administrative expense under this contract. Related-party administrative expense does not include amounts paid to a related-party for administrative costs actually incurred by the related party in connection with the administration of the contract.

Related-party administrative margin: Related-party administrative expense divided by qualifying revenue.

Related party medical margin: The difference between medical costs incurred, including a related-party relationship and those incurred in the absence of a related-party arrangement. An arrangement whereby a MCO pays a related party a sub-capitation. For example, because Medicaid medical expenses must reflect the costs that would have been incurred in the absence of any related-party relationship, the circumstance in which a MCO pays any related party a sub-capitation would necessitate calculation of the related party medical margin.